Immunizations

DOH supplies free vaccines for children 0-18 years only. This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Billing Instructions at:
http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/EPSDT.html

- Bill the Department for the cost of the vaccine itself by reporting the procedure code for the vaccine given.

- The Department reimburses providers for the vaccine using the Department's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

- If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E&M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M code with modifier 25. If you bill the E&M code without modifier 25 on the same date of service as a vaccine administration, the Department will deny the E&M code.

  Exception: If an immunization is the only service provided (e.g., an immunization only clinic) and a brief history of the client must be obtained prior to the administration of the vaccine, you may bill 99211 with modifier 25. The brief history must be documented in the client record.

Note: Meningococcal vaccines (CPT procedure codes 90733 and 90734) require EPA, please see Section H.

Billing for Infants Not Yet Assigned a ProviderOne Client ID

Use the mother's ProviderOne Client ID for a newborn if the infant has not yet been issued a ProviderOne Client ID. Enter indicator **SCI=B** in the *Comments* section of the claim to indicate that the mom's ProviderOne Client ID is being used for the infant. Put the child's name, gender, and birthdate in the client information fields. When using a mom's ProviderOne Client ID for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For a mother enrolled in a Department managed care plan, the plan is responsible for providing medical coverage for the newborn(s).**

Injectables

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

  ✓ RIG is sold in either 2 ml or 10 ml vials.

  ✓ One dose is allowed per episode.

  ✓ Bill one unit for each 2 ml vial used per episode.

Examples:

- ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
- ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill the Department for immune globulins using the HCPCS procedure codes listed below. The Department does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

Noncovered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1566
90284	J1562
90291	J0850
90384	J2790
90385	J2790
90386	J2792
90389	J1670
	Q4087, Q4088, Q4091, and Q4092

- The Department pays for injectable (see fee schedule) and nasal flu vaccines (CPT 90660) from October 1-March 31 of each year.

Note: CPT 90660 is covered by the Department for clients 19-49 years of age.

Therapeutic or Diagnostic Injections/Infusions
(CPT codes 96360-96379) [Refer to WAC 388-531-0950]

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 96372) in addition to an injectable drug code.
- The Department does not pay separately for intravenous infusion (CPT codes 96372-96379) if they are provided in conjunction with IV infusion therapy services (CPT codes 96360-96361or 96365-96368).
- The Department pays for only one "initial" intravenous infusion code (CPT codes 96360, 96365, or 96374) per encounter unless:
  - ✓ Protocol requires you to use two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second "initial" service code with modifier 59.

- The Department does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 96360-96361, 96365-96368, or 96372-96379. If billed in combination, the Department denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, the Department will deny the E&M code.

- **Concurrent Infusion:** The Department pays for concurrent infusion (CPT code 96368) only once per day.

Hyalgan/Synvisc/Euflexxa/Orthovisc

- The Department reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan, Synvisc, Euflexxa, or Orthovisc.

- The Department allows a maximum of 5 Hyalgan, 3 Euflexxa, or 3 Orthovisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

The injectable drug must be billed after all injections are completed.

- Providers must bill for Hyalgan, Synvisc, Euflexxa, and Orthovisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
J7321	Hyalgan/supartz inj per dose	Maximum of 5 injections Maximum of 5 units
J7323	Euflexxa inj per dose	Maximum of 3 injections Maximum of 3 units
J7324	Orthovisc inj per dose	Maximum of 3 injections Maximum of 3 units

Providers must bill for Synvisc, using the following HCPCS code:

HCPCS Code	Description	Limitations
J7325	Synvisc inj per dose	One unit equals one mg. One injection covers a full course of treatment per knee. Limited to one injection per knee in a six-month period. Maximum of 48 units per knee, per course of treatment.

- Hyalgan, Synvisc, Euflexxa, and Orthovisc injections are covered only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.

- The injectable drugs must be billed after all injections are completed.

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of: 5 Hyalgan injections, 3 Euflexxa injections, 3 Orthovisc injections, and 1 or 3 Synvisc injections (depending on formula).

- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, the Department limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although specific memoranda have been superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	112.84 (candiadal esophagitis); 117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02, V25.40, V25.49, V25.9. (contraceptive mgmt) allowed once every 67 days Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585.1-585.9 (chronic renal failure)
J2325	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585.6 (chronic renal failure)
J2916	Na ferric gluconate complex	585.6 (chronic renal failure)

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J3285	Treprostinil, 1 mg	416.0-416.9 (chronic pulmonary heart disease)
J3420	Vitamin B12 injection	123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487	Zoledronic acid (Zometa®), 1 mg	198.5, 203.00, 203.01, 275.42 (hypercalcemia)
J3488	Zoledronic acid (Reclast®), 1 mg	731.0, 733.01
J9041	Bortezomib injection	200.40 – 200.48 (mantle cell lymphoma) or 203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Subc inj interferon beta-1a	340 (multiple sclerosis)
J2323	Natalizumab injection	340 (multiple sclerosis). 555.0, 555.1, 555.2, 555.9 (crohn's disease). Requires PA. See *Important Contacts* section for information on where to obtain the authorization form.

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2, 174.0-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).
- The Department reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case management.
- The Department reimburses providers for one unit of Clozaril case management per week.
- The Department reimburses providers for Clozaril case management when billed with ICD-9-CM diagnosis codes 295.00 – 295.95 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- The Department does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

Botulism Injections (HCPCS code J0585, J0587, J0775)

The Department requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**. The Department requires PA for CPT code 95874 when needle electromyography for guidance is used.

The Department approves Botulism injections with PA:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
  - ✓ Nonsurgical treatment for Dupuytren's contracture (J0775 only)
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

Vivitrol (J2315)

The Department requires prior authorization for Vivitrol. It is also available when prior authorized through the pharmacy Point-of Sale (POS) system.

Allergen Immunotherapy [Refer to WAC 388-531-0950(10)]

Payment for antigen/antigen preparation (CPT codes 95145-95149, 95165, and 95170) is per dose.

Service Provided	What should I bill?
Injection and antigen/antigen preparation for allergen immunotherapy	✓ One injection (CPT code 95115 or 95117); ***and*** ✓ One antigen/antigen preparation (CPT codes 95145-95149, 95165 or 95170).
Antigen/antigen preparation for stinging/biting insects	✓ CPT codes 95145-95149 and 95170
All other antigen/antigen preparation services (e.g., dust, pollens)	✓ CPT code 95144 for single dose vials; ***or*** ✓ CPT code 95165 for multiple dose vials.
Allergist prepared the extract to be injected by another physician	✓ CPT code 95144
Allergists who billed the complete services (CPT codes 95120-95134) and used treatment boards	✓ One antigen/antigen preparation (CPT 95145-95149, 95165, and 95170); and ✓ One injection (CPT code 95115 or 95117).
Physician injects one dose of a multiple dose vial	✓ Bill for the total number of doses in the vial and an injection code
Physician or another physician injects the remaining doses at subsequent times	✓ Bill only the injection service

For an allergist billing both an injection and either CPT code 95144 or 95165, payment is the injection fee plus the fee of CPT code 95165, regardless of whether CPT code 95144 or 95165 is billed. The allergist may bill an Evaluation and Management (E&M) procedure code for conditions not related to allergen immunotherapy.

National Drug Code Format

All providers are required to use the 11-digit National Drug Code (NDC) when billing the Department for drugs administered in the provider's office.

- **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. **[WAC 388-530-1050]**

- The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros."

For example: The label may list the NDC as 123456789when, in fact, the correct NDC is 01234056789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***The Department will deny claims for drugs billed without a valid 11-digit NDC.***

Electronic 837-P Claim Form Billing Requirements

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

CMS-1500 Claim Form Billing Requirements

When billing using a **paper** CMS-1500 Claim Form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form must be listed **exactly** as follows (*not all required fields are represented in the example*):

19. 54569549100 Line 2 / 00009737602 Line 3

Line	Date of Service	Procedure Code	Charges	Units
1	07/01/07	99211	50.00	1
2	07/01/07	90378	1500.00	2
3	07/01/07	J3420	60.00	1

DO NOT attempt to list more than two NDCs in field 19 on the paper CMS-1500 Claim Form. When billing for more than 2 drugs, you must list the additional drugs must be listed on additional claim forms. **Do not bill more than 2 drugs per claim form.**

If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.

Physicians Billing for Compound Drugs

To bill for compounding of drugs enter J3490 as the procedure code. Enter the NDC for the main ingredient in the compound on the line level. Put compound in the notes field. Attach an invoice showing all of the products with NDCs and quantities used in the compound. Claims are manually priced per the invoice.